
Billing a Medicaid Client

Frequently Asked Questions (FAQs)

Last Updated 07/11/2011

- Q: Can you please post the link here of the May 27th WAC revision?
A: The revision to the WAC can be located at the following [website](#).
- Q: When are we going to have access to print this slide show?
A: The webinar PowerPoint will be posted on the Provider Relations [webinar page](#).
- Q: What about if the client receives services not stating they are signing up for benefits at the time of service then come back a month or two down the road and state that DSHS will pay for it. Are we obligated to bill and accept the DSHS or can we refuse it and have the patient pay?
A: Yes you are obligated to bill and accept DSHS payment upon notice of retro eligibility. You have a year from the date of service to bill us.
- Q: Can we bill family planning only clients also?
A: If you are a family planning only provider.
- Q: Can we bill dme without a waiver like bathroom equipment that we know is not allowed?
A: Bathroom equipment is a non-covered service. An ETR is available and the client can choose to waive that ETR option and pay on their own. The form was created just for scenarios like this. You must use the form. Only if it is an excluded service may you may bill without a waiver.
- Q: For a patient with a spend down, do we bill DSHS first even if we know they still have spend down to satisfy?
A: Yes
- Q: What is the definition of emergent dental?
A: A patient presenting with pain, infection, or trauma who can be treated with the specified set of services available under this benefit. Information about this benefit is now located in section 388- 531-1025 of the WAC under the physician services guidelines and page B-30 of the Physician- Related Services/Healthcare Professional Services Billing Instructions.
- Q: How long are we obligated to wait to bill the client when they state at the appointment they are signing up for benefits before holding the patient responsible for the fees?
A: You don't have to wait to bill the client, but if the client receives eligibility you would need to reimburse the patient and then bill DSHS.
- Q: Does bathroom equipment qualify as excluded services or non covered?

- A: Bathroom equipment is a non-covered service. You would need to offer to the client to pursue the ETR process for a non-covered services.
- Q: What about billing a code that is allowed by some providers but not others? The code I am having trouble with is 90807 which is a mental health code. They won't allow mental health nurse practitioners to bill it but I am assuming that other mental health providers can. Can I bill the patient for it if DSHS won't cover it for my type of provider?
- A: No you cannot bill a client for a service we do not allow you to bill us for. You should be only billing the codes that are allowed for the mental health ARNP per the billing guidelines. Provider type information for CPT code 90807 can be found in the Physician-Related Services/Healthcare Professional Services Instructions. This code is available to ARNPs who meet the criteria and are serving clients 18 years of age and younger, please see page D.11. If the ARNP does not meet these criteria, they should not be providing this service and should bill according to he/her scope of practice.
- Q: Can we bill clients for required forms that need to be filled out as a clerical charge?
- A: No
- Q: What happens when the client gets retro active coverage after the services have been rendered?
- A: You would need to refund the patient after eligibility is verified and bill Medicaid.
- Q: Where can we find information on DME excluded items vs. NON-Covered items?
- A: You can reference the [DME billing instructions](#) and the link to the [WAC](#).
- Q: Previously we were told that Adult Dental is an excluded service. Why would you need form?
- A: We do have the benefit we created for emergency oral health care, effective January 1, 2011. If the client presents with symptoms that qualifies for the oral emergency benefit package: trauma, infection, or pain; a set of services are available to treat that problem. If the client chooses a treatment the provider offers outside the emergency oral health benefits package the waiver is required because we had a covered service(s) available that could have met the clinical need. Check the Physician-Related Services/Healthcare Professional Services Instructions.
- Q: Do you need a 13-879 for a crown it is not a covered benefit?
- A: If the patient presented with pain, infection or trauma and the client chooses the crown treatment option instead of a covered service from the list of services under the emergency oral healthcare (EOH) benefit, you need the form signed- because there was a covered service available to the client and the client chose a service which is excluded. However, if it is a routine crown and the client's symptoms did not qualify them for the EOH benefit, you do not need to use the form because this is indeed an excluded service with no other covered service available.
- Q: If a patient claims that they are a self paid patient and we bill them, then they come back with the provider one card. Do we have to bill DSHS?
- A: Yes, after you verify the eligibility you would need to refund the patient and bill Medicaid.
- Q: If a patient comes in and pays for a service prior to service but we do not have the Medicaid form 13-879 filled out (example circumcision) do we need to refund the patient?
- A: We do not require repayment under these circumstances, but the provider needs to know this is

not a practice they want to repeat. If they were audited and there was a pattern of this, it could be a finding and result in their termination for not following our policies and rules.

Q: If a patient is APPROVED for orthodontic treatment by DSHS, and then loses coverage, can the parent be billed and made to sign a payment contract?

A: You can't "make" a client sign a payment contract. If this situation occurs, and the client is not willing to sign a payment contract, you would need to discontinue treatment.

Q: Can a client be billed for a second set of duplicate x-rays if the first set of duplicates is lost by the client, postal service or another clinic?

A: No

Q: For a high deductible 3rd party plan, can the deductible be billed to the Department for reimbursement or can we bill the client if the department does not cover?

A: You would bill DSHS if it is a covered service. If the third party paid more than DSHS allowable you would not be able to balance bill the client.

Q: Can DSHS clients be billed for mailing fees and missed appointment fees?

A: No

Q: We are an optometrist. If a child receives glasses thru DSHS and then wants to pay for a 2nd pair of glasses, do we need to have them sign a 13-879?

A: This would be a limitation extension since we allow one pair every 12 months. This additional pair would be considered through the prior authorization process. However, if the client wants glasses that are not what we allow under our program, they can sign the waiver and purchase the item of their choice.

Q: If patient has cnp coverage but admitted for detox, can we bill the patient without a DSHS form 13-879?

A: The CNP coverage includes coverage for the detox program. The department should be billed according to the billing instructions for [Inpatient](#) services and the [Physician Related Services](#).

Q: Adult yearly exams are an excluded service, so if a patient wanted to be seen we would be able to bill the patient for yearly exam and PAP?

A: Please follow the billing guidelines. A yearly exam for adults is not covered but a PAP is a covered service under the OB/GYN in the reproductive services section of the physician related billing instructions.

Q: Does the Form have to be complete 90 days before the services are performed?

A: It has to be completed no more than 90 days prior to the date of service. It cannot be done after the service.

Q: When primary insurance terms or has a temporary lapse, and client will not inform DSHS, claims deny for other payer. Can the client be billed?

A: No. You need to verify eligibility. You can bill DSHS with a copy of the denial EOB from the insurance company.

Q: What if you cannot locate any benefit information, say the patient just signed up and has not

- been added on DSHS, can we bill the patient?
- A: You can bill the client but must refund and bill DSHS if the client receives coverage.
- Q: Once the physical therapy units have been exhausted, how do we proceed?
- A: If you determine the client still requires therapy you may fill out the limitation extension/authorization form to request authorization for additional units. If Medicaid denies that additional care and the client wants to continue that care, the client may pay for the additional services after you and the client complete the form.
- Q: Can a client w/ DSHS as secondary be billed for the primary insurance deductible?
- A: No. Bill DSHS for the service. If the insurance payment is more than the DSHS allowed amount and we pay no more, there is no balance billing of clients.
- Q: Wouldn't the adult exam example be covered for the client as preventive services under healthcare reform?
- A: To date, health care reform has not changed the federal rules that govern Medicaid benefits. The federal rules that would mandate this coverage are still in "interim" status.
- Q: Can you bill a client for remainder of bill if they suddenly become ineligible during the course of treatment you have been authorized for?
- A: You should be able to bill the client for services on or after the date the eligibility for benefits ends. The loss of coverage should be discussed with the client as the client may choose not to complete the authorized treatment at their own expense. Be careful though, as the client may get reinstated their coverage.
- Q: When we have questions is there a live person we can go to? Customer service is reading the same instructions as we are and are not giving definite answers?
- A: You can try using the [contact us online system](#).
- Q: Can a range of typical office call CPT codes (such as 99212 - 99215) be used as the CPT billing code on DSHS form 13-879 when the patient seeks medical care for a non-covered diagnosis (such as obesity)?
- A: Yes
- Q: What is the definition of non covered versus excluded?
- A: Excluded Services - A set of healthcare services that we do not include in the client's benefit package. These are services that are not funded or not available because of Federal or state law. There is no Exception to Rule (ETR) process available for these services.
Non-Covered Service - is a specific healthcare service contained within a service category that is included in a medical assistance benefits package, for which the agency requires an approved Exception to Rule (ETR) (see WAC 388-5010160).
- Q: On QMB patients do they need a waiver signed for eye exams since it is non-covered by Medicare?
- A: Medicaid has its own policy for covering eye exams. If it is an exam that Medicare deems non-covered, the claim could be billed to Medicaid to see if the client is on a QMB program that covers routine eye exams. If the client is QMB only we will pay nothing because Medicare didn't pay anything. You would not need a waiver form if Medicare allows you to bill the client for this

service. If the client is QMB dual, then our coverage policy on eye exams would be applied for claims adjudication.

Q: Can you please clarify that a RCT for an adult patient needs form 13-879 even if the patient is not in any pain?

A: If the client is not in pain and therefore does not qualify for the emergency oral healthcare benefit, you do not need to have form 13-879 signed for a root canal, which is an excluded service.

Q: A circumcision is a non covered benefit by Medicaid, so this would not apply in this instance, correct ?

A: Circumcision's are a covered a service for medical issues. Because it is considered non covered normally you would need to follow the exception to rule policy if the client wanted to see if we would pay for it. The client could choose to waive the ETR and sign the form to pay for the service. Please note: It seems highly unlikely we would ever pay for a circumcision under an ETR.

Q: Where can you find a more detailed description on the benefit packages?

A: The [ProviderOne Billing and Resource Guide](#) will explain how to determine if the services are covered and what the benefit package descriptions are. Also you can refer to the program specific [fee schedules](#).

Q: Can you bill the remainder of orthodontic treatment to the patient if they lose coverage during the course of orthodontic treatment?

A: You should be able to bill the client for services on or after the date the eligibility for benefits ends. The loss of coverage should be discussed with the client as the client may choose not to complete the authorized treatment at their own expense. Be careful though, as the client may get reinstated their coverage.

Q: Can a patient choose to waive the Prior Authorization process and sign DSHS form 13-879 and pay for the service? Assume the service could be covered under PA.

A: You would need to follow the PA process. A client cannot waive the prior authorization requirement for a covered service. It is the provider's responsibility to follow the Department's or managed care organizations PA process, ensure translation or interpretation is provided to limited English proficiency clients who agree to be billed, and retain all documentation which demonstrates compliance.

Q: Is authorization required when billing for the primary's deductible portion? Is there specific billing codes used for a deductible portion?

A: We currently have a recorded webinar and PowerPoint on how to bill DSHS secondary to a commercial insurance. It can be located at the Provider Relations [training page](#).

Q: We are contracted with CHPW for Healthy Options. If a Healthy Options patient that is assigned to Molina or Regence BlueShield seeks non emergent care at our clinic, can we may bill the patient WITHOUT DSHS form 13-879?

A: The client should be referred to a provider that is contracted with their health plan and you should document if you choose to provide services for the client. Form 13-879 doesn't need to be signed.

- Q: Would we be correct in assuming that when a routine eye exam is denied as a maxed benefit and no waiver was signed, we can bill the patient?
- A: There is a limit on routine frequency so the provider would need to have checked and told the client it was used and then if the client still wanted it and no diagnosis was made, they could bill the client without the waiver but they should have the client sign the office's financial responsibility form.
- Q: From what I can get from your website and webinar excluded services are services that are no longer covered, such as glasses and contacts for adult?
- A: Not just "no longer covered"; they are no longer available under any circumstances.
- Q: Do non-covered services require a waiver?
- A: Correct non covered requires a waiver; BUT an excluded services do not require a waiver.
- Q: Is there somewhere that explains the difference between excluded services versus non-covered services?
- A: Excluded services are those optional services under CFR for which we have no funding and cannot provide to clients: adult hearing aids, vision aids, or non emergent dental. The new WAC 182-501-0060 may help you as will our new definitions WAC.